PEDIATRIC HEALTHCARE ASSOCIATES PATIENT REGISTRATION FORM

(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY) DATE: _____

OFFICE: _____

Mother / Father / Guardian Information (*for child(ren) listed below*)

Name_____ Date of Birth_____

Address_____ Home Phone ( )_____

City_____ Cell Phone ( )_____

State_____ Zip Code_____ Work Phone ( )_____

Employer Name_____ E-mail Address _____

Father / Mother / Guardian Information (*for child(ren) listed below*)

Name_____ Date of Birth_____

Address_____ Home Phone ( )_____

City_____ Cell Phone ( )_____

State_____ Zip Code_____ Work Phone ( )_____

Employer Name_____ E-mail Address _____

Marital Status (circle): Married Single Separated Divorced Widowed

IF DIVORCED: ☐ JOINT CUSTODY ☐ SOLE CUSTODY ☐ LEGAL DOCUMENTS PROVIDED

Patient Information (*Please list **ALL** children*)

Legal Name	Preferred Name	PCP in our Office	Sex M/F	DOB mm/dd/yy	Child lives with? (Mother/Father/Both)

Address child lives at if other than above:

Address _____ Phone ( ) _____

City _____ State _____ Zip _____

Emergency Contact (other than parent):

Name _____ Relationship _____

Home Phone ( )_____ Work Phone ( )_____ Cell Phone ( ) _____

Authorized Care Givers

The following people are authorized to discuss personal health information or bring my child to Pediatric Healthcare Associates for evaluation and treatment, including immunizations:

Name _____ Relationship_____ Phone ( )_____

Name _____ Relationship_____ Phone ( )_____

Name _____ Relationship_____ Phone ( )_____

Name _____ Relationship_____ Phone ( )_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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In order to help us comply with federal and state reporting and record keeping when using state provided vaccines, please indicate your race and ethnicity.

RACE:

- ☐ Caucasian
- ☐ Black
- ☐ Hispanic
- ☐ Asian
- ☐ Native American
- ☐ Asian Pacific American
- ☐ Pacific Islander
- ☐ Subcontinent Asian American
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian
- ☐ Black Non-Hispanic
- ☐ Other Race or Ethnicity
- ☐ White Non-Hispanic
- ☐ Race Not Reported – Refusal
- ☐ Race Not Reported – Don't Know
- ☐ Race Not Reported – Not Ascertained

ETHNICITY: ☐ Latino/Hispanic ☐ Not Latino or Hispanic ☐ Other ☐ Refused

Language predominantly spoken _____

How did you hear about our practice_____

COMPLETION OF THIS SECTION IS <u>OPTIONAL</u>

GENDER IDENTITY

- ☐ (M)ale – person specifies gender identity as male.
- ☐ (F)emale – person specifies gender as female.
- ☐ (FTM) Transgender Male / Female-to-Male – person specifies gender identity as transgender male.
- ☐ (MTF) Transgender Female / Male-to-Female – person specifies gender identity as transgender female.
- ☐ (G) Genderqueer – neither exclusively Male nor Female.
- ☐ (O)ther – person specifies a gender identity that is other than the options of Male, Female, Transgender Male, Transgender Female, or Genderqueer.
- ☐ (D)eclined

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

_____ Initial Pediatric Healthcare Associates (**circle one**) **can** **cannot** treat and administer injections/vaccines to my unaccompanied child/children (if over 16 years of age).

_____ Initial I _____ authorize Pediatric Healthcare Associates to contact me by telephone with medical information pertaining to my child(ren)'s care. If I am unavailable, this authorization gives Pediatric Healthcare Associates permission to leave this information either on my answering machine or with a member of my household.

Phone number to call with information: _____

_____ Initial I authorize Pediatric Healthcare Associates or whomever they designate to evaluate and treat my above named child and to release to our insurance company any information acquired in the course of my child's examination or treatment, and to receive all payments for such examination or treatment. PHA has my permission to release any diagnostic studies, report, etc., to a specialist involved in caring for my child.

_____ Initial I understand that all health care decisions, including immunization authorization, must be made by a legal guardian or parent.

_____ Initial A parent / guardian / or authorized care giver is to be present at every visit. If someone else is bringing your child, **we will need prior written authorization** that includes authorization for treatment, your contact information, and insurance and co-pay payment authorization for this visit.

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PAYMENT POLICIES

_____ Initial **Insurance Information**: Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, the charges are your responsibility until a copy of the insurance card(s) is received. In order for services to be billed to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.

_____ Initial **Account Balances**: When insurance information is received *after* the timely filing requirements of your insurance company, the charges for those services are your responsibility. You are responsible for payment of services unpaid by your insurance company and for timely payment of your account. PHA reserves the right to reschedule or deny future appointments for delinquent accounts.

_____ Initial **Payments:** PHA accepts cash, checks or credit cards. Payment plans can also be setup by contacting our billing department at (203) 452-8329.

_____ Initial **Co-Payments:** are expected to be paid at the time service is rendered. If payment is not received at the time of service, there will be an additional $10 fee. All returned checks will be subject to a service charge of $15.

_____ Initial **Self-Pay:** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Please ask about the Vaccine for Children program.

_____ Initial **Divorce Situations:** The parent bringing the child in for care is responsible for payment of co-payments. Both parents are responsible for payment on unpaid balances, regardless of divorce decree. If payment issues exist, they must be resolved between the parents.

_____ Initial **Referrals:** If your plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements and contact the referral specialist at this office to request a referral to be processed *prior* to the specialty appointment.

_____ Initial **Evening, Weekend & Holiday Code:** Please be aware, we report all evening, weekend and holiday visits to your insurance carrier. This code may **or may not** be covered.

_____ Initial **No Shows:** A $50 no show fee will be assessed for all well and specialty consult visits not previously cancelled.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ Initial I acknowledge that I have received the Notice of Privacy Practices, which explains how my health information will be handled in various situations.

My signature below indicates I am the legal guardian for the patient(s) listed on the front page, that I have provided accurate information to the best of my knowledge, and I understand and agree to the provisions as stated.

Signature of Parent / Legal Guardian _____ Date _____

Print Name of Parent / Legal Guardian _____